WORKPLACE HEALTH and SAFETY: Report of PHASE/MNA Focus Groups
University of Massachusetts Lowell
Lee Ann Hoff, RN, PhD and Craig Slatin, ScD, MPH

A Two Part Series

The U-Mass Lowell PHASE in healthcare research project has been a five-year NIOSH-funded study of health disparities among healthcare workers. The case study and focus group research addressed our questions about how healthcare system restructuring has affected work health and safety. Our partnership with the MNA provided us the opportunity to learn about the working conditions nurses face in a range of healthcare settings. MNA members, including elected leaders, local unit leaders, occupational health advocates and staff nurses, employed mostly in hospital environments, participated in a series of seven focus groups on the following topics: General health and safety; violence and abuse; diversity and discrimination issues; post-injury return to work experiences, and healthcare system restructuring.

SUMMARY OF FINDINGS **(Part 1)**

A. Work-related Injury, Illness, Violence and Abuse

Types and source of injury: These include direct bodily harm and threats to health such as HIV infection from needle sticks, sharps and bodily fluids of patients; exposure to hazardous materials; and muscular-skeletal disorders traced to heavy lifting, inadequate equipment, and too few staff for lifting very heavy patients. Nurses attributed frequent URIs, chronic fatigue and **spastic bowel** to short staffing, double shifts and mandatory overtime. One nurse described the work environment as a "merry-go-round turned to high" so to avoid falling off "you have to increase the speed at which you work."

The categories of assault and abuse included physical but non-life threatening attack, life-threatening violence, and verbal and emotional abuse. Violence and abuse occur across practice settings, with patients as primary perpetrators and direct care staff the primary targets. Nurses attribute increasing assaults and abuse to lack of preventive programs and management support, inadequate staffing and security measures, admission of patients with histories of violence, the "free flow of people [into healthcare facilities] and increased aggressiveness of patients and families," short staffing and long waits for service leading to patient frustration. Abuse included verbal attacks by physicians and the emotional toll of "constant negative evaluations" by management, labeling them as "malingerers" if injury was not physically apparent, and humiliating them in front of patients and other staff.

Impact of stress and trauma on physical and emotional health: The stress emanating from the fast pace, overtime, noise from telemetry, fear of potentially dangerous patients, and chronic fatigue is insidious–out of the nurse's immediate awareness–but cumulative, eventually revealing itself in conditions such as dental pain, sleep deprivation, a compromised immune system, and subsequent increased vulnerability to infections and injuries from various exposures. As one nurse said: "... nursing is just one shortcut after another, and many shortcuts are unhealthy for the nurse and patients."

Nurses distinguished the trauma from abuse in relation to the cognitive status of the perpetrator: If the patient is impaired, it is easier to excuse the assault. Yet, there is a tendency to interpret assaults in healthcare settings as "part of the job" unlike, for example, recognizing assault in a supermarket as a "criminal act." For example, when complaining about a sexually assaultive patient, a supervisor said, "... we can't do anything. He has a right to be here..." until a court order is obtained. Similarly, in a dramatic and life-threatening hostage situation, management was apparently oblivious of the emotional toll on the nurse trying to bring a violent patient under control and save her own and others' lives; she pressed the nurse to continue in her caregiving role with "Hurry up, let's go" with no opportunity offered for post-incident debriefing or support. Also noted was a class difference in management's response to assault of workers, with more attention paid, for example, if the assaulted victim was a physician.

Disparities among workers at risk: Overall, direct care workers are at greatest risk of injury, especially nurses and nursing assistants, although this varies according to type of injury, language, ethnicity, and class. The upward age trend and accompanying decreased physical stamina among nurses (95% female) puts them at greater risk of injury from stressors of short staffing, heavy workloads, long shifts, and many years of work. Although nurses note less frequent injury of managers and physicians–"They don't see it [e.g. heavy lifting] as part of their job"–chemical injury and exposure is perceived as "the great equalizer" because regardless of job description, "the fact that you were in the building, breathing on a regular basis was your risk factor. But the way you were treated varied on the basis of what your status was."

B. Reporting Behavior, Policies, and Management Attitudes

Overall, reporting may be formal (following agency policies), or informal, encompassing the communication process between workers and management, and among workers themselves. Whether or not nurses follow explicit reporting policies depends on a variety of factors, including type and seriousness of injury, attitudes of management, cognitive status of perpetrator, socioeconomic status of worker and formal supports, and threat to job stability following report of injury. Among these factors, most influential is the severity of injury–regardless of source–that is marked by need for immediate medical treatment, physical incapacity to continue working because of injury, and/or threat of serious illness such as HIV/AIDS or Hepatitis C from needle stick or sharps injury.

Nurses tend not to report an injury perceived as "self-inflicted" or accidental (e.g., bumping one's head), whereas physical assault by patients are more often reported, although such reporting is complicated by the cognitive status of the perpetrator. This is a significant factor in a nurse's attempt to find meaning in what happened and take appropriate follow-up steps after injury. It refers to the widespread differentiation in medical and public health arenas between "intended" and "unintended" injuries. If the perpetrator is cognitively impaired, there is a propensity to accept the injury as "part of the job," as exemplified by this statement, "But he's demented, you know."

Delayed reporting occurs when the perceived seriousness of the injury or subsequent pain may not be apparent until days after it occurred. Reporting behavior is also complicated by a policy requirement to cite a "specific instance" of injury which is not possible in cases of the "cumulative" effect of some injuries. For such insidious injuries, some nurses attribute their "collapse" to "getting old, tired and [working] too hard."

Reporting is inherently connected to management attitudes and any prospects of compensation for injury. Nurses noted their cynicism about the complexity of reporting procedures and management's response to reporting. They described experiences with Workers Compensation policies as generally negative and their perception of its inherent unfairness. One called it a "system riddled with red tape and aggravation" and requiring "jumping through hoops to see a doctor." Nurses also noted their lack of educational preparation to deal with safety and workers' compensation issues prior to joining the workforce and/or being injured on the job.

Nurses cited management indifference, blatant victim-blaming, or even hostile rebuke of a reporting nurse; for example, management sent a nurse-educator to "teach somebody what, obviously, they did wrong." implying "you really did it yourself, or you don't know what you're doing" or "It's in your head, you're overreacting or you must have psychiatric problems." Another nurse said that the nurse manager would "rip up the incident reports" and verbally attack nurses for "trying to cause trouble... Why are you making out these incident reports just because someone got punched in the face?...What's the big deal?" Nurses therefore get to the point of saying "Why bother?" In an instance of verbal abuse with no physical injury by a surgeon, management indifference was exemplified with "...he's like that, or he talks to everybody that way...It's like a no-win situation."

Overall, nurses said that "lack of support almost is worse than the illness or what happened to you." When the burden of responsibility for documenting injury is on the injured party instead of the agency, nurses felt re-abused by the system. They also cited the money that could be saved by solving the occupational health problems versus legally intimidating the injured worker. In a similar vein, they cited "throwing away experienced nurses" [instead of buying latex-free gloves, for example]: Rather than dealing with the Workers' Compensation system, a nurse said, it's easier to "just take Motrin and go on working." On the other hand, one nurse acknowledged "we put ourselves in harm's way" [in contrast to others who assert themselves], while another said: "Adaptation is a terrible thing, you do it because it's expected of you. And eventually you don't even realize how bad it is for you."

Acknowledgments to: MNA-member focus group participants; focus group ***coordinators****, Evie Bain and Kathy Sperrazza; and PHASE team members Eduardo Siquiera, and Beth Wilson for their assistance with this research.*

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SUMMARY OF FINDINGS **(Part 2)**

C. Health Care Restructuring and Nurse Empowerment Issues

Nurses described today's health care system as a business model in which hospitals function like a hotel complete with ads for patients and concierge ("instead of a healthcare worker") to answer questions. Entry facades resemble the "Taj Mahal... but then you enter a patient care unit and it completely drops off." Nurses perceive money as the "bottom line" in this model, hence the emphasis on keeping patient numbers up in a desperate attempt to survive financially. Staff must "speed up, work faster, work smarter, and take up more tasks in the clinical arena." In this restructured work environment, nurses experience a constant sense of urgency in a vicious cycle of ever increasing pace of work. They associate this environment to their increased stress levels, self-care neglect, and physical symptoms.

One nurse said this about the high-powered management model: "A lot of what's called restructuring has nothing to do with best practice. It doesn't have scientific evidence [to support it]. It's really someone [chief executive, the proverbial emperor with "no clothes"] sent by the Board with an idea and saying 'OK, there's some goals and here's how we'll get to those goals.' And if someone objects and says, 'wait a minute, you've got no clothes on again'...it's just too easy for them to say, OK, you're not with the team. Get out. And we'll just get some team players in here."

Nurses also cited the systematic "downsizing, reconfiguring and outsourcing" of nursing

staff through restructuring, that is, "extending nurses" by hiring cheaper health aides in schools and moving home health care patients to another agency with piecemeal billing protocols in which patients get lost in the shuffle. "And when we say stop, you need to look at this person who needs more than you're offering [they say] Get into the real world. This is not how we do things now." Other evidence of restructuring is reliance on machines vs. nurses for very sick patients, plus pressure for early discharge of these sick patients. While patient acuity level is rising, staffing levels are down. Describing the impossibility of meeting care needs of two neurology patients with ventricularostomies in their heads , and trying to explain the situation to an upset family, one nurse said: "I simply can't be in two places at one time. And they [the family] didn't buy it, so I just said to hell with this, I'm leaving."

Cost of restructuring in money, worker safety, and quality of patient care: While citing financial incentives (e.g., hiring lower-paid direct care workers) that have "escalated dramatically with restructuring," nurses say that it's not that there is no money [for nurses' salaries], it's that "the money is simply oozing to the top" in the form of the salaries and bonuses paid to middle and upper management. Put another way, nurses say there is no shortage of nurses, just a shortage of those willing to work for low wages; and they describe the $10,000 bonuses to attract nurses as "stopgap measures." Another cost (vs. financial saving) in restructured healthcare is the repeated introduction of new guidelines and subsequent need for continuous re-learning.

A clinical nurse specialist cited a dramatic example of "cost" to hospitals in failing to use inside nursing knowledge (vs. high-powered sales pitches from non-nurses) in management decisions before purchasing expensive equipment. That is, after "taking the doctors to dinner" and dealing with the VP for materials, "they bring me in after the sale is closed." When she then raised questions about the item, she was told "it's a done deal." And then they fly in another nurse specialist "from Dallas or Minneapolis to teach us how to use it."

One nurse used the metaphor of the "widget" to describe the cost of the manufacturing model in staff time and quality of patient care. The software computer recording of patient care was meant to document that nurses "managed care" in an "efficient way to bill for and not be denied payment. Nurses noted that the computer software does not allow one "to override the system to put in your assessment, what you saw. You could only do the checking off...that you had the patient turn, cough, and deep breathe"–leaving no place for "nursing judgment." This underscores mis-guided application of the manufacturing model in which "the widget is always the same," whereas in healthcare, every patient is different. One nurse stated: "We've been sold out by those nurses who became business managers" who apply the concept of the widget as though every patient is the same, thus by-passing the reality of "whole patient ambience."

Besides these costs of provider reorganization resulting from restructuring, nurses described the pain of nurse managers who must implement layoffs. In one VNA, for example, the entire home health aide Departments (mostly ethnic minority workers who lost all benefits) was eliminated because it was "a money loser." Cynicism from these

actions combines with apathy: “The women who have tolerated it for a long time just accept it...The norm is we don’t speak up because you don’t bite the hand that feeds you... The women are much more apathetic the longer they are in a system, and new people who won’t tolerate it just leave.” Contract workers–hired to replace professional and other workers who have been let go or simply quit–are thought to have no buy-in or incentive for institutional loyalty in job performance.

Injury prevention, Union and other sources of support: Nurses cited NIOSH as a source of support for its “guidelines” for injury prevention, although these are not enforceable. Most importantly, they singled out the MNA union for the “very powerful role” it plays in acting on behalf of injured workers and injury prevention such as through protective contracts, its legislative agenda for safe staffing, and changing legal definitions which originally excluded nurses as objects of felonious assault. The union “gives the individual nurse and smaller groups of nurses the support of their colleagues...the ability to say no [to effects of restructuring].. We’re here to take care of patients. That’s our legal responsibility...and that’s why you’re getting paid to resist some of these foolish changes and bring forth some things that do help patients.” This nurse said being organized is a tremendous asset to the healthcare environment, and offers the satisfaction of being able to say “enough is enough and having the union say, this is what the agreement is.”

Nurses also discussed whistle-blower protection, intimidation, and the difficulty of fighting the system. A nurse who had worked with several nurse managers over 15 years time said that those who “try to work with the system...and try to prove things and stand up and advocate for nurses and patients, are the ones that ended up being pushed out the door.”

PRELIMINARY ANALYSIS

In one way, the nurses’ voices about workplace health and safety speak very powerfully for themselves, providing vivid data-based rationale for whatever action nurses and others may wish to take on behalf of themselves and fellow healthcare workers and–by extension–improving the quality of patient care.

Emerging from qualitative analysis is the overarching theme of healthcare restructuring in which healthcare agencies are redefined as businesses, patients are redefined as “widgets” in a factory-like line of production, and service delivered to these “widgets” is redefined as a commodity. Together, the re-definitions central to restructuring reveal that profit margins supercede concerns about and investment in basic training programs and policy implementation to protect the health and safety of healthcare workers. The reality of healthcare restructuring is often the giant invisible to workers on the ground who are faced with the grind of daily duty, engrossed in demands, rescue strategies, and survival of themselves and patients.

We learned that the health and safety of nurses and other healthcare workers is often disregarded as a priority in many healthcare agencies. Where MNA members have been

able to work with concerned managers, wonderful progress has been made in health and safety of workers, for example, in one hospital system's nationally acclaimed model for violence prevention. By and large, though, we learned that healthcare facility owners, the various payers who demand full healthcare service for reduced costs, and the workers' compensation insurers and government agency have failed to see the importance of protecting employees' health and safety, and at worst have established a system to evade the employer's legal responsibility to provide a health and safe workplace.

Patient safety concerns are primary, yet owners and managers fail to recognize that patient safety is dependent upon healthcare worker safety. Instead of implementing comprehensive health and safety programs, nurses and other workers are blamed for their injuries and illnesses, and patients are considered the unavoidable cause of injury risks– they are too heavy, too old, or have dementia, and nurses have to accept the consequences of these patients' behavior as part of the job. But fortunately, the MNA counters these arguments and beliefs and points out that increased staffing, better working conditions, making both worker and patient health and safety a system-wide priority, and giving voice to nurses' collective knowledge can and will make healthcare work safe and effective.

We have deep appreciation for the opportunity that the MNA and focus group participants provided us to learn about these healthcare issues. As our analysis is completed and we publish our findings, we hope to provide support to the movement for creating a healthcare system with universal access, affordability, high quality, and working conditions that reflect the dedication and commitment of nurses and all healthcare workers.

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